

Murky Waters of Medical Practice in India

Ethics, Economics and Politics of Healthcare

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Pervasive greed in contemporary medical practice does not spare even the poorest of the patients. Medical expenses are now considered one of the major triggers of impoverishment in the country. A rapid influx of advanced technologies in areas ranging from drug discovery to diagnostics has generated a greater reliance on assistive technology by the practitioners of modern, Western medicine transforming patients into cases and physicians into technocrats. This paper is a contribution to the ongoing debate on the quality and standards of medical practice in India. It challenges the argument that markets can bring out the optimum in healthcare and shows how market forces have, in fact, militated against patient interests.

A series of recent articles in popular press as well as in academic journals has rekindled the debate on the dwindling sanctity of medical practice in the country (Berger 2014; Chowdhury and Nundy 2014; Sengupta and Nundy 2005). Most of the claims and arguments question the professional ethics and integrity of medical practitioners. Reports of exploitation of patients through a combination of high fees, irrelevant and excessive diagnostics and irrational medications have fuelled discussions on the healthcare sector as one of the most corrupt in the country. In most cases, as the studies cited above have argued, both the private and government health sector are equally culpable, with the former exhibiting more blatant profit-driven patterns.

This paper highlights some of these interconnected determinants to explain how departures from idealistic notions and expectations from the medical fraternity can be associated with the interplay of ethics, economics and politics of regulation. It also brings a social science perspective to this discourse, which so far, has been largely dominated by voices within the medical community.

The Seeds of Discontent

First, we consider the normative aspects of medical practice. The science as well as the art of healing has been long considered as one of the greatest services to humankind, earning the practitioners the glory of being in the “noble profession.” Esteem translates into expectations, strengthened by established norms within the profession itself. These norms are aptly summarised by the Hippocratic Oath binding a practitioner’s moral obligations to the patient. A combination of such professionally-vetted moral commitments and popular expectations of the society at large builds the normative basis for medical practice, against which departures are assessed. Such normative adjudging is, however, common to all professions—though with varying degree and is more so for professions with a social orientation such as teachers. It is likely that increasing sophistication and technical knowhow have raised expectations and norms, against which individual actions as well as that of the profession are evaluated.

The recent history of modern medicine and medical practice is typified by two major phenomena that have rocked the foundations of the normative principles of medical profession—and the expectations from the profession. The first pertains to the rapid influx of advanced technologies in areas ranging from drug discovery to diagnostics which has generated greater reliance on assistive technology by the practitioners of

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modern, Western medicine. Sadly, this has come at a cost of replacing age-old traditions and expertise of building medical opinion based on the patient's history.

Bernard Lown (2007), a renowned cardiologist, laments that such over-reliance on diagnostic tests and machine-generated results has transformed patients into mere “cases” and converted physicians into technocrats. I argue later how such negative influence of technologies has skewed the economic behaviour in the healthcare sector. But it can be reasonably considered that the first seed of distrust about the healthcare provider is sown when at the very first physician–patient interaction, the latter is directed to undergo a battery of “tests.” The medical opinion is often contingent on the results of these tests.

The second factor is the contribution of the global economic order. Its impact is even more far reaching. Neo-liberal doctrines and free-market exponents have managed to influence the transformation of healthcare into a freely-tradable commodity in conventional markets similar to the ones we are used to for common consumer goods. But as keen observers on the interplay of medicine and philosophy such as Pellegrino (1999) have observed, the underlying assumptions of “marketisation” of healthcare are deeply flawed both on the grounds of ethics, established social sanctions and even more seriously from the perspective of economic theory itself. Consequences of commodification are considered to be “ethically unsustainable and deleterious to patients, physicians and society,” succeeding only to synthetically differentiate a physician's role as a money-maker from that of a healer.

As many commentators have observed, a large number of medical practitioners have responded to these changes in a manner contrary to the ethical tenets. A heady concoction of ubiquitous technology, profit motives of a hungry healthcare “market” and decaying principles has created a horde of greedy professionals. Like the wily Shylock hell-bent on extracting his pound of flesh from Antonio in the *Merchant of Venice*, this emerging class of medical mafiosi acts undeterred in filling its own coffers and in the process ends up pushing the sanctity of the entire profession on a downhill.

Berger (2014) and others have levelled strong accusations at the pervasive setting of corruption in the healthcare sector, where innovations only reinforce the vicious cycle of flawed professional ethics strengthen institutionalised systems of kickbacks and foster utter disrespect for patient's rights and interests. It is not surprising, thus, that researchers have found poor quality of medical advice in India both across urban and rural areas (Das et al 2012).

More seriously, concerns have been raised within the medical community of a fearful tendency among many fresh medical graduates. They are ignorant of the ethical basis of medical practice. There is deliberate neglect of the traditions of studying the medical history of patients and a concomitant reliance on studying just the epidemiology and pharmacological aspects of diseases. All these failings result in patient–physician interactions that are shorn of trust and faith.

A lot has been written about the excesses committed by the physicians including acts of gross negligence and exorbitant pricing of consultations and other services. While most of the evidence is based on personal experience, anecdotes and reports in the popular media, there is hard data to incriminate the healthcare sector. An analysis of data from nationwide household surveys has shown a strong link between risks and incidence of catastrophic medical expenditures and impoverishment, on one hand and use of medical care from the private sector, on the other (Berman et al 2010). Pervasive greed in contemporary medical practice does not spare even the poorest of the patients and it is thus not surprising that medical expenses are now considered one of the major triggers of impoverishment in the country. Blatant disregard for both professional ethics and the traditional codes of humanness—that have been the bedrock of medical practice—has vitiated the atmosphere to such an extent that acts of kindness, benevolence and honest medical advice take on the proportion of folklore and receive widespread adulation. But such exceptions only affirm that the norms and values associated with medical practice are facing near-total erosion and physicians are no longer regarded as humane in popular perception. One wonders if even the champions of commodifying healthcare and the free-market proponents imagined such near-total transformation of medical practice and allied services in less than quarter of a century.

Invisible Hand, Visible Consequences

To many serious observers of contemporary healthcare systems, a common trait of the recent and fast-paced transitions in the health sector across emerging economies is the gradual erosion of the role of national governments in the health sector and over-enthusiastic substitution by private interests and enterprises. The neo-liberals believe the influx of private capital in the health sector of this country, riddled with a dysfunctional public sector, has resulted in efficiency and better-quality services. The ideological moorings of this school of thought lies in the neoclassical theory of efficient markets. Put simply it argues that for any economic goods and services competitive markets automatically ensure an equilibrium aided by the invisible hand—free interplay of the equilibrating forces of demand and supply.

The implicit set of assumptions—often critical to most of the conventional economic theories—behind such a premise is founded on the understanding that the suppliers of healthcare, that is, the physicians and hospitals, are on an equal footing with the prospective consumer, or the patient. Economics itself tells us how deeply flawed such assumptions are. Aptly referred as an “abnormal economics” (Hsiao 1995), the idiosyncrasies of the healthcare sector are all-too-many that clearly suggest why conventional markets are bound to create more problems than they promise to solve. While it is beyond the scope of this article to delineate the main arguments, it may be useful to briefly indicate why a system relying on private markets cannot be expected to serve interests of the population at large, in a welfare state of today.

Within the ambit of healthcare, clinical services such as those offered by physicians and at hospitals, particularly those sought for curative reasons can be considered to be of the highest “private” nature.¹ In simpler terms, private benefits to the consumer of such services are higher than the benefits accruing to the society at large—as in case of other healthcare services such as vaccinations, or better means of sanitation and drinking water. However, even for such a “private” service being traded, markets are unable to automatically guarantee socially optimal outcomes. There are a few reasons for this.

First, clinical services are perhaps one of the best illustrations of asymmetric information, where the level of information about the services—the therapeutic options and the medical knowhows—vary significantly between the sellers (physicians) and the buyers (patients). Commonly referred as the principle of utility maximisation under assumptions of a rational consumer, this buyer–seller interaction is, however, quite unlike that we do with, say, grocers, where one is almost certain about what one is looking for and what would provide the highest utility, given the available budget. Shopping for healthcare, in times of need, is almost unrealistic. In the case of medical care, a patient or the prospective consumer may at best have some good guesses: the expected costs of different treatment options, such as the fees of a particular physician, or the charges of a particular hospital. So consumer sovereignty, a critical ingredient of competitive markets, is severely undermined.

Second and related, in market-based transactions where the individual may not know the best decision, economic rationality allows for agents—a different set of individuals or institutions—which are engaged by the former to take decisions on his behalf. However, for the clinical services being discussed, the agents (physicians) also earn their livelihoods from such advice and such dual role of agents and providers create imperfect agency. What happens as a consequence is a case of induced demand for the services offered by the physician, including that for surgeries, technologies and drugs. Under need of medical opinion patients rarely have the time or mental state to exercise rational choice through careful weighing of alternative clinical options. For profit-driven physicians this is a strong incentive to leverage their comparative supremacy and dictate the composition and quantity of healthcare being consumed, or offered to the patient. So much for optimality.

A few empirical illustrations may be useful to justify how the “abnormalities” cited above are not theoretical constructs, but hard facts that explain recent patterns and trends of undesirable outcomes in the Indian healthcare sector. These illustrations will underscore the fallacy of the optimality of private markets in clinical services.

The first concerns India’s largest social health insurance programme, the Rashtriya Swasthya Bima Yojana (RSBY).² Our fieldwork in rural areas of Birbhum District in West Bengal leads to some interesting revelations: a lion’s share of the

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health conditions under the RSBY-covered hospitalisations was accounted by surgeries for cataract, hernia and hydrocele, removal of appendix, certain tumours and other rather trivial illnesses. Distressingly even medical procedures such as hysterectomy—at times conducted upon women in their early 30s—with wider public health impacts are reportedly on the ascendance. Data on the epidemiological pattern of hospitalisations in the same population collected earlier reveals a clear departure once it is tallied with patterns for coverage-usage under RSBY: very few of the otherwise common hospitalised illnesses such as diarrhoea, fevers, malaria and other general surgeries, including those for accident injuries, were in the list of reasons for seeking hospitalised care under the RSBY insurance programme. Such anomaly between diseases otherwise prevalent and for those RSBY support is availed confirms an imperfect physician agency leading to induced demand.

Abnormal Economics of Induced Demand

A few other studies have earlier reported similar findings: pilferage of government funds by private empanelled hospitals in the absence of standard guidelines and weak monitoring or audits (Gothoskar 2014); a higher-than-usual share of low severity, or primary healthcare conditions in the aggregate claims (Rathi et al 2012); wider public health implications of high rates of procedures such as hysterectomies (Desai 2009; Seshadri et al 2012). Qualitative data too finds physicians and hospital managers admitting unabashedly that such tendencies are quite common. They allege that the “package-rates” under RSBY for the more prevalent ailments, usually in higher need of hospitalisation, are insignificant and usually limited to standard daily rates. More “profitable” daycare procedures (surgical procedures for removal of cataract, hydroceles, or appendectomy, for example) are encouraged. Here, the “abnormal” economics of induced demand in clinical services explains what appear as acts of immorality and unethical practices by the medical community.

Furthermore, since this involves availing of insurance coverage which someone else pays for (here, the government), it also qualifies as classic instance of the “moral hazard” problem—referring to situations where excess, inappropriate or unnecessary medical care is consumed or utilised because of health insurance coverage. Normally, this problem is expected when the insured avails of such excesses and the insurer has no way to prevent such leakages. However, as illustrated above, a combination of supplier-induced demand and moral hazard problems—both central issues in the health economics literature—can act in tandem to generate undesirable consequences. The same literature also unequivocally states that in the face of such problems, a market-based allocation system for clinical healthcare services is bound to fail and not automatically guarantee optimality. Economics will measure quantitative losses to the state exchequer in this case, in money terms; the society at large feigns ignorance and these acts pass off as the normal order of the day, only leading to anguish and public outrage when major excesses occur.

The next instance refers to the rapid increase in the proportion of caesarean section (cs) deliveries during

childbirths. Established norms of cs rates consider that “... there is no justification for any region to have cs rates higher than 10–15%” (Gibbons et al 2010). Latest nationwide estimates in India (National Family Health Survey (NFHS)-3, 2005–06) indicate that in at least six states (Kerala, Goa, Andhra Pradesh, Tamil Nadu, Karnataka and Punjab) cs rates are above 15% and in another six states (Jammu and Kashmir, Himachal Pradesh, Tripura, Delhi, Maharashtra, and West Bengal) they lie within 10%–15%.

Some studies, including recent survey estimates from a few states, indicate that if deliveries conducted in urban areas or in private hospitals are considered, the rates jump to around 40%–60%. Cross-national evidence, including that from India, has simultaneously suggested a strong financial motive in pushing up the rates in a fee-for-service system, where cs deliveries are considerably more remunerative to the physician or hospital, compared to a vaginal delivery (Pai 2000). Our ongoing work buttresses such propositions. Considering falling fertility levels as a negative income shock to the physician or the hospital conducting deliveries, we examined simple linear regressions between fertility levels (measured by total fertility rates) and cs rates across 25 Indian states. We found a strong, significant effect of both absolute levels of fertility and changing fertility trends on cs rates as well as on trends in cs rates during the decade and a half from 1992 to 2006.

In fact, the impact of fertility levels on cs rates across the states becomes stronger over the three time periods considered (simultaneous to the three NFHS waves in India: 1992–93, 1998–99 and 2005–06). This again, presents a clear economic explanation to a commonly observed phenomenon: when fertility levels fall and fall fast, they spur physicians and hospitals to insure expected earnings in a fee-for-service system. They, accordingly, increasingly opt for cs deliveries, which are more remunerative, hence ensuring their earnings remain largely unaffected (Gruber and Owings 1996).³ It is easy to comprehend the adverse public health impacts of such blatant economic motives perverting medical judgment in the choice of delivery methods and mucking the overall scenario.

Irrational Prescriptions

The final evidence I cite here relates to economic motives bulldozing into medical decision-making through drug-prescribing behaviour of physicians. It also proves how defective linking of different sub-markets (for example, those related to pharmaceuticals and medical diagnostics) for healthcare, besides creating undesirable medical practices, can have adverse and far-reaching public health impacts. Much has already been written about steady rise in corrupt practices of kickbacks and commissions flowing from pharmaceutical and medical equipment manufacturers to physicians and hospitals across the country in return of prescribing or advocating use of their products to unknowing patients.

A good indicator of such tendencies is the rampant and irrational prescribing of antibiotics—India ranks among the countries with highest per capita usage of antibiotics according to recent studies (van Boeckel et al 2014). Evidence from a

number of cities has clearly indicated that antibiotics are prescribed in about 30%–40% of all clinic-based consultations; most such antibiotics are not required from the clinical viewpoint. This again shows how imperfect physician agency— Influenced by narrow self-interests—leads to high levels of supplier-driven demand for drugs, which has far-reaching public health consequences. They are responsible for anti-microbial resistance (AMR) in populations as well as pushing up costs of treatment—with several financial implications, given that drugs account for bulk of out-of-pocket healthcare expenditures. Such undesirable responses of the medical practice to skewed economic stimuli, as this shows, not only affects the direct consumers but has health implications for the future.

This discussion on the economic theory behind medical behaviour and decision-making converge in one crucial—and long pointed out—respect: the fallacy that markets are infallible in all aspects of human behaviour. In fact, what we see in India is a reckless commitment to this misconceived notion, making healthcare in the country one of the most privatised systems globally. But negligent and conniving political interests have successfully ensured that such reckless privatisation is consistently pursued in a system characterised by fragmented, unregulated markets with little institutional sophistication other than a few badly mauled normative assumptions. Such incomplete marketisation of healthcare has made the scenario murkier; so much so that even assessing the quantum of such a parallel economy of medical care sustained by this gamut of unfair, unethical practices appears daunting. The interactions have turned out to be more vicious in recent years owing to the growing cartelisation of private healthcare players in the garb of corporate hospitals and “wellness centres,” which have merely institutionalised corrupt practices through innovative means.⁴

Politics of Regulation: Quid pro Quo?

A common point of the discussion on contemporary healthcare system in India and the emerging predominance of the different private markets of healthcare⁵ is the gradual withdrawal of the state from these markets and visible policy reluctance to have basic, rudimentary checks and balances against such unbalanced concentration of power. The organisation of the private medical sector in India continues to be nebulous with untrained, informal medical practitioners and super-specialty corporate hospitals thriving in the same ecosystem reminiscent of a surprisingly symbiotic relationship. A set of archaic laws related to setting up and functioning of clinical establishments and bye-laws of specific trade bodies do exist, but are hardly of any impact to discourage unethical, corrupt or ill-motivated practices such as those discussed above.

The Indian healthcare sector—often billed as a sunshine sector of the new economy—is perhaps the one with most immature, hoary regulations, be it wide variations in the costs of medical processes, drugs and fees for physician services or a streamlined process for addressing complaints and grievances of affected patients in their role as consumers in a market-based system. Little regulation in supplementary markets such as

that of medical education has echoing effects on unfair trends in medical practice. Upward spiralling of the costs of private medical education—but with little standardisation across rapidly mushrooming institutes—has been found to encourage fresh medical graduates to “recover costs” at earliest possible opportunities. In this melee, the government is little beyond a mute spectator (at times during excesses such as the infamous Ketan Desai episode) while there are allegations that certain sections of bureaucracy and the political circles are in active connivance with powerful sections of the private healthcare establishments. The unbridled powers of a section of the Indian Medical Association to influence any attempt to regulate the sector, or stonewall reform measures such as opening up of diploma courses to address the vast shortfall of medical and paramedical personnel often stand in way of any meaningful legislations to curb unfair practices. In this muddle, the role of the Medical Council of India appears increasingly unclear: in promotion of medical education and training in this overtly-privatised environment, regulating quality and pedagogy of medical training as well as framing ethical standards.

Conclusions

This paper brings to the fore a broad-based outlook to the ongoing debate on the quality, standards and scruples that characterise medical practice in India. While most of the illustrations and focus of the arguments presented above have been India-centric, similarities could easily be located among health systems in many low and middle-income countries having unplanned, skewed service-mix between the public and private healthcare sectors, with the latter thriving mostly on a fee-for-service system with little coverage of formal insurance schemes.

I have attempted to place ethical and economic perspectives in the debate and highlighted how the interactions between the normative aspects of physicians’ roles and their economic motives explain most of the departures from benchmarks of societal expectations from them. In the fast-changing landscape of medical care in the country, there is a marked absence of attempts to standardise and regulate rapid proliferation and concentration of monopolistic power in the hands of a few corporate players.

It may be useful to note in this context that this problem is shared across social sectors beyond healthcare, such as school education. This view refers to a prominent “missing middle” in social sector services. There is a wide chasm between a monolithic public sector offering services of poor quality but at a lower cost or a vast informal sector such as in healthcare and a largely corporatised private sector often operating in franchisee business models, sprouting rapidly as the economy opens up and offering so-called “international standards” in education or healthcare, but at hugely pumped-up costs. What has gone missing and inconspicuously faded into oblivion, are public hospitals known for good quality treatment or schools offering education at lower costs, or private physicians such as the neighbourhood general practitioners, well-regarded for both efficiency and a distinct personal touch of assurance. In

fact, an overspecialisation of medical practice, has not only robbed the healthcare system of its structural balance following standard practice of referrals, but also has been a key element in encouraging the plethora of malpractices discussed earlier. Unless, major corrective steps are initiated to reinstate this “missing middle” and public systems strengthened significantly to ensure expected quality standards, inequalities will only breed further contempt for the medical practice at large.

Scarce popular awareness of consumer rights and claims in such a highly-privatised market for clinical and related services, even in modern cities and among the upwardly mobile society, also spell risks for unsuspecting and often

hapless patients. The call for affirmative action by the civil society at large from groups such as the People’s Health Movement and other commentators is a welcome step in catalysing public action.

The fundamental forces of economic motives are inextricably linked with a pay-for-service, private sector-oriented healthcare. Unless fundamental corrections of such overt reliance on an unregulated private sector are systematically carried out through a combination of strengthening of the public health system, installing watchdog and effective consumer rights institutions and alternative financing mechanisms, healthcare sector reforms will be elusive.

NOTES

- 1 In public economics, a private good/service is defined by their attributes of excludability and rivalness in consumption, meaning that consumption of the good/service by an individual reduces the quantity available to others (rivalness) and that it is possible to provide the goods/services to only those who demand and agree to pay for it at prices that equate aggregated demand of and supply for the good.
- 2 RSBY provides for cashless hospitalisation facilities for eligible households, generally those officially identified as poor, or below the state-specific poverty lines, up to a maximum ceiling of Rs 30,000 per year. Based on a given schedule of charges for a long-list of procedures, this facility can be availed in empaneled hospitals available in all districts, with most of them being secondary-level facilities in the private sector.
- 3 In the Indian context, the only notable study referring to these motivations is Ghosh and James (2010).
- 4 For example, Sanjay Nagral (2014) has reported institutionalising the system of standard commission rates payable for referrals in well-known multi-specialty hospitals in Mumbai under the shady garb of marketing promotions.
- 5 Healthcare is considered to be comprised of five closely linked markets: physician services, institutional services such as hospitals, input factors, professional education or medical training and financing (such as private health insurance).

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